

Outside of City Limits
Dr. Louis Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-8

01201

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:
Rt. 1, Frostburg, Bldg. - Labale

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 1, Frostburg, Bldg. - Labale
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Margaret "Bore" Anderson

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George W. Anderson

7. Birth date of deceased (mo., day, yr.) December 5, 1884 6.(c) If alive, give age..... years

8. AGE: Years 62 Months 2 Days 22 It less than one day..... hrs. min.

9. Birthplace Frostburg, Allegheny, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name John H. Bore

13. Birthplace Detroit, Mich.

14. Maiden name Mary Jane Tennant

15. Birthplace Borden Mines, Md.

16. Informant Mrs. Mary J. Tyree

Address Rt. 6, Cumberland, Md.

17. Burial Date thereat March 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Stoffer

Address Cumberland, Md.

19. March 1, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-5-47 to 2-27-47 and that I last saw him alive on 2-18-47

Immediate cause of death congestion of the gallbladder DURATION 1 year

Due to cholelithiasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

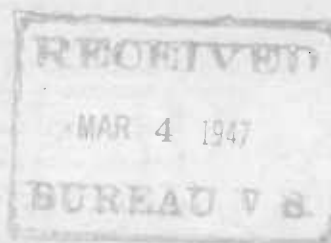
23. SIGNATURE L. Brings M.D. M. D. or other

Address 59 Greene St. Date signed 3-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 820

CERTIFICATE OF DEATH

01202

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Allegany
 City or town Conacoche
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Water Station Run
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Conacoche
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Water Station Run
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elspeth B. Arnold

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife James B. Arnold
 7. Birth date of deceased (mo., day, yr.) Nov 11, 1865 6. (c) If alive, give age 1 years
 8. AGE: Years 81 Months 3 Days 12 If less than one day
 hrs. min.

9. Birthplace Scotland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Own home
 FATHER 12. Name Thomas Ritchie
 13. Birthplace Scotland
 MOTHER 14. Maiden name Margery Blake
 15. Birthplace Scotland
 16. Informant Thomas Arnold
 Address Conacoche, Md
 17. Burial Date thereof Feb. 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oak Hill Cemetery
 Location Conacoche, Md
 18. Funeral director Wm. Eichhorn
 Address Conacoche, Md
 19. Feb 28 19 47 Janette M Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 47 at 8:15 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 2 19 47 to Feb 23 19 47
 and that I last saw him alive on Feb 15 19 47

Immediate cause of death Cerebral Hemorrhage
 DURATION
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Hewitt M. Lodge M. D. or other
 Address Conacoche, Md Date signed 2/26/47



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01203

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 2 years.
 Hospital, institution, or street address where death occurred:
440 Williams Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella Dorcas Ault.

3. (b) Social Security Number

None.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife John Ault.

Deceased

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 22d, 1856

8. AGE: Years Months Days If less than one day
90 11 21 _____ hrs. _____ min.9. Birthplace Falls City, Penn.
(Town, county, and state)

10. Usual occupation Retired House wife.

11. Industry or business

12. Name Martin Mitchell
13. Birthplace Falls City, Penn.14. Maiden name Martha Jane Hinebaugh
15. Birthplace Falls City, Penn.16. Informant Mrs. Edith Schlossnagle,
Address Oakland, Md.17. Burial Date thereof Feb. 4/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oakland Cemetery.
Location Oakland, Maryland.18. Funeral director E. B. Bolden
Address Oakland, Md.19. Feb. 4, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1947, at _____ M

21. I CERTIFY that death occurred on the date above stated that I attended deceased from
Nov. 15, 1946, to Feb. 1, 1947
and that I last saw him alive on Nov. 15, 1946

Immediate cause of death

Myocardial infarction
 Generalized arteriosclerosis
 5 yrs.

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE _____ M. D. or other
 Address _____ Date signed _____

RECEIVED
FEB 11 1947
BUREAU V B
2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 81

01204

1. PLACE OF DEATH:

County allegany
 City or town Lonscom and
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hodgson ClinicHow long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County allegany
 City or town Frostburg, P.F.D. #1
 (If outside city or town limits, write RURAL and give nearest town)

Street No. B of 205
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sherin Lee Baer

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white child

6. (b) Name of husband or wife

6. (c) If alive, give age 11 years7. Birth date of deceased (mo., day, yr.) Feb. 17, 1947

8. AGE: Years Months Days If less than one day
11 hrs. min.

9. Birthplace Lonscom and

(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Richard Baer13. Birthplace Gilmore, md14. Maiden name Janet Kerling15. Birthplace Westonport, md16. Informant Richard BaerAddress Frostburg md R.F.D. #1

17. Burial Date thereof Feb 28 47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory allegany CemeteryLocation Frostburg, md18. Funeral director M. EichhornAddress Lonscom and

Feb 28 47 Janet M. Pool
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28th 1947, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 17 1947 to Feb 28 1947and that I last saw him alive on Feb 25 1947

Immediate cause of death

premature birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

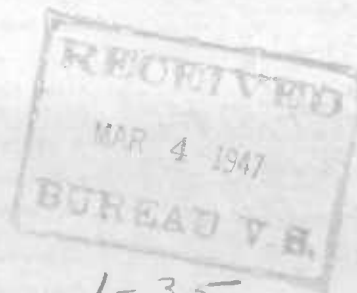
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson - M.D.

M. D. or other

Address Romney, md Date signed Feb 28 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No.

01205

40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

ADOLPHUS BAILEY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEWIDOWED6. (b) Name of husband or wife Maudie Bailey7. Birth date of deceased (mo., day, yr.) Feb. 4, 18788. AGE: Years 69 Months — Days 24 It less than one day _____ hrs. _____ min.9. Birthplace W. VA.
(Town, county, and state)10. Usual occupation RETIRED MINISTER

11. Industry or business

12. Name Eliza Bailey13. Birthplace Harrison County, W. Va.14. Maiden name Eliza Thomas15. Birthplace "16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereon March 7, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hamdale CemeteryLocation 2 mi. N. Oakland, Md.18. Funeral director Nerbert C. LeightonAddress Oakland, Md.19. Mar. 1, 1947 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 28, 1947 19 _____ at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2:25 19 47 to 2:28 19 47and that I last saw him alive on Feb. 28, 1947Immediate cause of death Renal andhemorrhageDURATION 5Due to Heart

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. F. Williams M. D. or otherAddress Cumberland Date signed Feb 28, 1947

RECEIVED
MAR 4 1947
BUREAU V.S.

1-30-

MARYLAND STATE DEPARTMENT OF HEALTH

01206

DR. TOLSON

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For persons not in home give residence of mother) ALLEGANY
State MAITLAND County
City or town LONA CONING
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROBIN STREET
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME BEEMAN, JOSEPH MR. Joseph Beaman
3. (b) Social Security Number 716-05-5747

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife EDITH BEEMAN
7. Birth date of deceased (mo., day, yr.) AUGUST 12, 1893
8. AGE: Years 53 Months 6 Days 12 If less than one day hrs. min.

MEDICAL CERTIFICATION 10:45 P.M.
20. DATE OF DEATH FEBRUARY 24, 1947

9. Birthplace PENNA.
(Town, county, and state)
10. Usual occupation RESTAURANT Manager and Owner
11. Industry or business

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27- 1946 to 2-24- 1947
and that I last saw him alive on 19

12. Name GEORGE BEEMAN Beaman
13. Birthplace Unknown.
14. Maiden name REBECCA COOK
15. Birthplace MARYLAND

Immediate cause of death Carcinoma of Liver (Hepatomas) with metastases in dorsalt lungs and skull.
Due to Primary ventral,
Due to lungs and skull.
Other conditions
(Include pregnancy within 3 months of death)

16. Informant Anna May Beaman
Address Robin St., Lonaconing
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 28, 1947
(month) (day) (year)

Major findings of operations
Autopsy results as above + lung abscess.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

Cemetery or crematory Laurel Hill
Location Muscow, Md.
18. Funeral director W. Eichhorn
Address Lonaconing, Md.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

19. Feb. 27, 1947
(Date rec'd by registrar) Registrar J. P. Franklin, M.D.

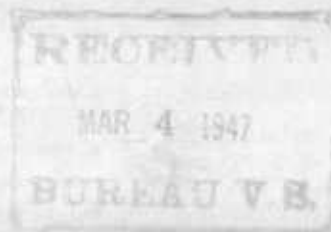
23. SIGNATURE Howard R. Tolson, M.D.
M. D. or other Cumberland, Md.
Address Cumberland, Md. Date signed 2-27-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01207

M V

40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Accident
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Wallace Beckman

3. (b) Social Security Number

213-12-9104

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 8, 18998. AGE: Years Months Days If less than one day
47 9 1 _____ hrs. _____ min.9. Birthplace Accident, Garrett, Maryland
(Town, county, and state)10. Usual occupation Sawmill worker11. Industry or business Sherman & Berk Frazee12. Name John W. Beckman13. Birthplace Maryland14. Maiden name Harriett Wilson15. Birthplace Maryland16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial Date thereof Feb 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beckman CemeteryLocation Pleasant Valley, Md.18. Funeral director John J. HofferAddress Cumberland, Md.19. Feb. 11, 1947 J. P. Traubler, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947 at 9:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him Dead Feb 9 1947

Immediate cause of death

Shock, severe concussion of DURATION 2 days
brain also fracture of leftDue to Fractured, left clavicle &
ribDue to being hit by a truck 5 miles
south of Accident Md 2-7-1947

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

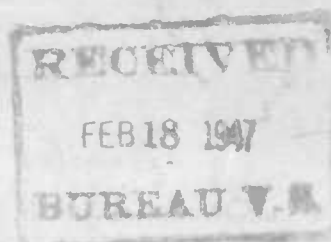
Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-7-1947Where did injury occur? 5 miles south of Accident Garrett Co Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Hit by a truck while putting on chains of his truck
injured at work? yes23. SIGNATURE H. V. Derrington M.D. M. D. or otherAddress Cumberland Md Date signed 2-9-47



2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

C1208

40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
512 Hill St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 512 Hill St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mary Jane Beckwith

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 16, 19438. AGE: Years Months Days If less than one day
3 11 15 hrs. min.9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Thomas Beckwith13. Birthplace Petersburg, W. Va.14. Maiden name Mary Jane Jounger15. Birthplace Morgantown, W. Va.16. Informant Thomas BeckwithAddress 512 Hill St., Cumberland, Md.17. Burial Date thereof 3 FEB 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. Feb 3, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 19 47 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her Dead Feb. 1 19 47Immediate cause of death Suffocation & 3rd. degree burnsDURATION About 2 hrs.Due to Bedroom caught fire while children were sleeping in bed.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-1-47Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury see above Injured at work?23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. OtherAddress Cumberland, Md. Date signed 2-1-1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

Reg. Dist. No. 01209 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:
512 Hill St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 512 Hill St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Thomas E. Beckwith

3. (b) Social Security Number

None

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife None
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 17 April 1944
 8. AGE: Years 2 Months 10 Days 13 It less than one day _____ hrs. _____ min.

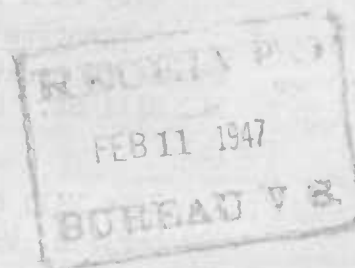
9. Birthplace Cumberland, Allegany Co., Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name Thomas E. Beckwith
 13. Birthplace Petersburg, W.Va.
 14. Maiden name Mary Jane Jounger
 15. Birthplace Morgantown, W.Va.

16. Informant Thomas E. Beckwith
 Address 512 Hill St., Cumberland, Md.
 17. Burial Date thereof 3 FEB 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director Louis Stein, Inc.
 Address Cumberland, Md.
 19. Feb 3 19 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 19 47 about 2.40 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him alive on Feb. 1 19 47
 Immediate cause of death Suffocation & 3rd. degree burns
 DURATION at once
 Due to Bedroom caught fire while children were sleeping in bed
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 2.1.47
 Where did injury occur? Cumberland Allegany Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) home
 Means of injury see above Injured at work?
 Deputy Medical Examiner - Allegany Co.
 23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other _____
 Address Cumberland Md. Date signed 2-1-1947



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01210

4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years.Hospital, institution, or street address where death occurred:
512 Hill St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 512 Hill St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William E. Beckwith

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

single6.(b) Name of husband or wife None6.(c) If alive, give age None years7. Birth date of deceased (mo., day, yr.) 5 July 19418. AGE: Years Months Days If less than one day
5 6 26 hrs. min.9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Thomas E. Beckwith13. Birthplace Petersburg, W.Va.14. Maiden name Mary Jane Jounger15. Birthplace Morgantown, W.Va.16. Informant Thomas E. BeckwithAddress 512 Hill St., Cumberland, Md.17. Burial Date thereof 3 FEB 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. Feb 3 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH Feb. 1 19 47 at 2.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him in Dead Feb 1 19 47Immediate cause of death degreeSuffocation & 3rd/ burns atonceDue to Bedroom caught fire whilechildren were sleeping in bed

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2.1.47Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury see above Injured at work?Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 2-1-1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No.

01211

40

1. PLACE OF DEATH:

County... Allegheny
City or town... Chesapeake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pa County... Bedford
City or town... Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
Street No... Route 1, Flintstone, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roger Theodore Bennett

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Child

6. (b) Name of husband or wife

6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) Jan 25, 1947

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Chesapeake, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Feb 5, 1947J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 2, 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2, 1947 to Feb 2, 1947
and that I last saw him alive on Feb 2, 1947

Immediate cause of death

DURATION

Pneumonia5 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. J. Franklin, M.D.

M. D. or other

Address

41 Bennett

Date signed

Feb 5, 1947

11379

[Faint, mostly illegible handwritten text, possibly a letter or report.]

[Faint handwritten notes and a rectangular stamp.]
BUREAU V.M.
RECEIVED
JAN 20 1947

[Faint handwritten notes and a date stamp.]
2-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Allegany
 County Cumberland
 City or town Life
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
465 Independence St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 465 Independence St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Henry Bockhouse

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Bessie Davis
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 31 1875
 8. AGE: Years 71 Months 1 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Allegany Co, Maryland
 (Town, county, and state)
 10. Usual occupation Glass Worker
 11. Industry or business Maryland Glass Works
 12. Name Wilhelm Bockhouse
 13. Birthplace Germany
 14. Maiden name Anna Walters
 15. Birthplace Germany

16. Informant Miss Elsie Bockhouse
 Address 465 Independence St, Cumberland, Md.
 17. Burial Burial Date thereof Feb 5 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St Lukes Cemetery
 Location Cumberland, Md.
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Feb 4 19 47 J. P. Traukha, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 47 4-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him alive Dead Feb. 3 19 47

Immediate cause of death Coronary thrombosis DURATION at once
Arterio-sclerosis several years
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
 Address Cumberland Md Date signed 2-3-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

01213

Reg. Dist. No. 40

DR. A. JONES

1. PLACE OF DEATH
 County ALLEGANY
CUMBERLAND, MD.
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State WEST VIRGINIA County MINERAL
RIDGELEY
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ROUTE 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME
WM. HOWARD BURKHART

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JAN. 30 1947 6. (c) If alive, give age..... years

8. AGE: Years Months Days It less than one day
25 hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name HOWARD BURKHART SR.

13. Birthplace PENNA.

14. Maiden name KATHLEEN CLARK

15. Birthplace WEST VIRGINIA

16. Informant Howard Burkhardt

Address Ridgely St. Va.

17. Burial Date thereof Feb 26 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bellevue Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Feb 26 47 Registrar Jr. P. Franklin, M.D.
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

FEBRUARY 25, 1947 12:44 A.M.

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 18 to Feb. 25 1947

and that I last saw him alive on Feb. 24, 1947

Immediate cause of death

Broncho pneumonia DURATION 2 days

Due to Chronic gastritis 3 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Arthur F. Jones Jr. M.D.

Address 110 S. Centre St. Date signed 2-25-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0110

UNITED STATES DEPARTMENT OF JUSTICE

ALBANY, NEW YORK

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MAR 4 1957
BUREAU V.S.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 40

01214

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

73 Green St (home) Fell dead on
kitchen floor

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 73 Green Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Francis Joseph Carbine

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary Carney Carbine6. (c) If alive, give age 74 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 12, 1872

8. AGE:

Years

75

Months

1

Days

10

If less than one day

.....hrs.min.

9. Birthplace

Mt. Savage, Md.

(Town, county, and state)

10. Usual occupation

Fireman

11. Industry or business

Allegany Hospital

FATHER

12. Name

Martin Carbine

13. Birthplace

Canada

MOTHER

14. Maiden name

Catherine McQuade

15. Birthplace

Baltimore, Md.

16. Informant

Mrs. Mary Carney Carbine

Address

73 Greene St., Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 25, 1947
(month) (day) (year)Cemetery or crematory S. S. Peter & PaulsLocation Cumberland, Md.

18. Funeral director

Charles L. George

Address

202 Greene St. Cumberland, Md.

19.

(Date rec'd by registrar)

Feb. 24 47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 19 47 at 11.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on Feb. 22 19 47

Immediate cause of death

Coronary occlusion

DURATION

atonceDue to Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

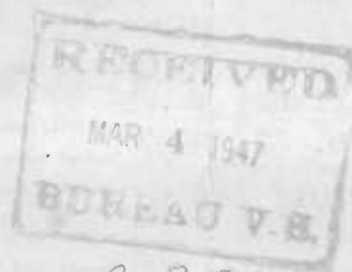
Injured at work?

Deputy Medical Examiner - Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. of Allegany CoAddress Cumberland Md. Date signed 2-23-47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

01215

Reg. Diat. No. 4

1. PLACE OF DEATH: County <u>Allegany</u> City or town <u>Cumberland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>214 Oak St.,</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Allegany</u> City or town <u>Cumberland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>214 Oak St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>George Herman Carroll</u>				3. (b) Social Security Number <u>705-12-3261</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Irene Wiley Carroll</u>				2D. DATE OF DEATH <u>Feb. 8,</u> 19 <u>47</u> at <u>11:15 A</u>			
7. Birth date of deceased (mo., day, yr.) <u>May 12, 1893</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>2 yrs.</u> 19 <u>45</u> to <u>19</u> <u>47</u> and that I last saw him alive on <u>Feb. 7</u> 19 <u>47</u>			
8. AGE: Years <u>53</u> Months <u>8</u> Days <u>26</u> If less than one day hrs. min.		6. (c) If alive, give age years		Immediate cause of death <u>Coronary artery occlusion</u>			
9. Birthplace <u>Bluemont, Va.</u> (Town, county, and state)				DURATION <u>3 years</u>			
10. Usual occupation <u>Car Repairman</u>				Due to <u>Myocarditis, chronic</u>			
11. Industry or business <u>B. & O. R.R. Co.</u>				Due to <u>Surg.</u>			
MOTHER		FATHER		Other conditions (Include pregnancy within 3 months of death)			
12. Name <u>George W. Carroll</u>		13. Birthplace <u>Va.</u>		Major findings of operations Date of op.			
14. Maiden name <u>Virginia - Unknown</u>		15. Birthplace <u>Va.</u>		Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
16. Informant <u>Mrs. Irene Carroll</u> Address <u>214 Oak St. Cumberland, Md.</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>Feb. 11, 1947</u> (month) (day) (year) Cemetery or crematory <u>Berryville Cem.</u> Location <u>Berryville, Va.</u>				23. SIGNATURE <u>W. E. Owens M.D.</u> M. D. or other Address <u>133 Virginia Ave</u> Date signed <u>2/9/47</u>			
18. Funeral director <u>Charles L. George</u> Address <u>Cumberland, Md.</u>				19. (Date rec'd by registrar) <u>Feb. 10, 1947</u> <u>J. P. Franklin, M.D.</u> Registrar			

RECEIVED

FEB 18 1943

BUREAU V.L.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-5

CERTIFICATE OF DEATH



01216

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
Mt. Savage
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Stella Tilden Cessna

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Perry Cessna

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 27th. 1879

8. AGE: Years 61 Months 5 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Cameron

13. Birthplace Va.

14. Maiden name Elizabeth Winkel

15. Birthplace Va.

16. Informant Mrs. Mary Leethead

Address 117 Dignity Court, Chesapeake, Va.

17. Burial, cremation, or removal, Which? Burial Date thereof 2-8-1947
(month) (day) (year)

Cemetery or crematory St. Georges

Location Mt. Savage, Md.

18. Funeral director Jacob W. Waples

Address Frederick, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1947 at 10:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20th, 1947 to February 5, 1947

and that I last saw him alive on February 5, 1947

Immediate cause of death _____ DURATION _____

Carcinoma Stomach 2 years

Due to _____

Due to _____

Other conditions Carcinoma Liver & Mesenteric Glands.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. Moseley M. D. or other _____

Address Mt. Savage Md Date signed 2-7-1947

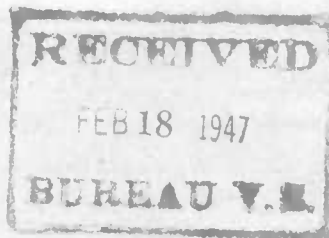
19. Feb. 7, 1947 Thomas McDermott
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

21310



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 60-0

CERTIFICATE OF DEATH

01217
40
Reg. Diat. No.

1. PLACE OF DEATH:

County AlleganyCity or town Burnsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Bresaptown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Girl Clayton

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Infant

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 19 47 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-20- 19 47 to 2-20 19 47and that I last saw him alive on 2-20-47 19 47

Immediate cause of death

True heart if
the cord

DURATION

3

Due to _____

Due to _____

Other conditions

born with heart beating
no breathing

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

L. Whinn
MD
M. D. or other
Address 59 Greene St. Date signed 2-21-47

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

Feb. 20, 1947

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

2 hrs.

min.

9. Birthplace

Burnsville, Maryland
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 47J. P. Franklin, M.D.
Registrar

RECEIVED
FEB 25 1947
BCHLAD V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown
 109-3/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01218

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Franklin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
James's Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Allegany
 City or town Franklin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 Mill St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John Connolly
 6. (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Aug - 10 - 1869

8. AGE: Years 77 Months 7 Days 13 If less than one day hrs. min.

9. Birthplace Exhaust, Allegany, Md
 (Town, county, and state)

10. Usual occupation Dance Teacher

11. Industry or business

12. Name James O' Connor

13. Birthplace Ireland

14. Maiden name Withering Bolin

15. Birthplace Ireland

16. Informant Richard Connolly

Address 14 Mill St. Franklin, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 2-26-1947
 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Franklin, Md

18. Funeral director Jacob Wapner

Address Franklin, Md

19. 2-26-1947 (Date rec'd by registrar)

Wm. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Feb 23 1947 and that I last saw him alive on Feb 23 1947

Immediate cause of death Chronic Myocarditis DURATION 2 yrs

Due to Arterio sclerosis

Due to

Other conditions Bronchitis Chr.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Nancy N. Roe M. D. or other

Address Franklin, Md Date signed Feb 23 1947

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FEB 28 1947

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1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
122 Center St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 122 Center Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

James Joseph Conway

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1931

8. AGE: Years Months Days If less than one day

15

10

20

hrs.

min.

9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)10. Usual occupation student11. Industry or business public school12. Name James Conway13. Birthplace Honover, Md.14. Maiden name La Masch15. Birthplace Honover, Md.16. Informant James ConwayAddress Frostburg, Md.17. Burial Date thereof Feb 17, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michael'sLocation Frostburg, Md.18. Funeral director J. J. QuerstAddress Frostburg, Md.19. 2-18 19 47 Mr. Harvey V. Re
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 47, at 4:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 19 46 to Feb 13 19 47 and that I last saw him alive on Feb 7 19 47Immediate cause of death Chronic Nephritis

DURATION

several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Lane Jr MD M. D. or otherAddress Frostburg, Md. Date signed 2-15-47

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1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01220

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

Allegheny HospitalHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 East Second St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Ellie L. Conway

3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1880

8. AGE: Years Months Days If less than one day

66 1 25 hrs. min.9. Birthplace Port Jervis N. Y.
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business at Home12. Name James Conway13. Birthplace Ireland14. Maiden name Ellen Geary15. Birthplace Ireland16. Informant Wm E. ConwayAddress Cumberland17. Burial Date thereof Feb 13 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter & Pauls Cem.Location Cumberland18. Funeral director Louis Stein IncAddress Cumberland19. Feb 12 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 19 47 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 24, 19 47, to Feb. 10 19 47and that I last saw him/her alive on Feb. 10, 19 47

Immediate cause of death

DURATION

Cerebral apoplexy 18 da.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature]

M. D. or other

Address Cumberland, Md.Date signed 2-12-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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2-36-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1862)

CERTIFICATE OF DEATH

Reg. Dist. No. 01221 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Allegany Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cornwaukenville
(If outside city or town limits, write RURAL and give nearest town)Street No. — Ins Garage Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Joseph C. Corrigan

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 18658. AGE: 82 Years Months Days If less than one day
hrs. min.9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation grocer11. Industry or business Retired12. Name Matthew Corrigan13. Birthplace Ireland14. Maiden name Anne Garvey15. Birthplace Ireland16. Informant Benton CorriganAddress Cumberland Ind.17. Burial Date thereof Feb 22 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patrick's Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Feb 21 47 J. P. Houckling, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-7-47 1947 to 2-19-47 1947and that I last saw him alive on 2-18-47 1947

Immediate cause of death.....

Fractured left femur 12 da.

Due to.....

Coronary occlusion Sudden

Due to.....

Other conditions.....

.....

.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

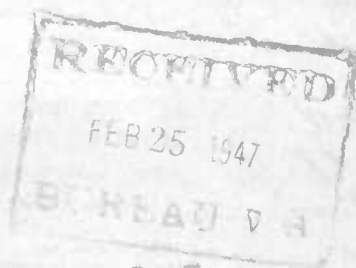
.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of 2-7-47Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Slipped & fell Injured at work? no23. SIGNATURE [Signature]M. D. or other Dr.
Cumberland, Md. Date signed 2-19-47



1-35

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01222 40

1. PLACE OF DEATH:

County Allegany
City or town Summers Island (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Summers Island
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hazen Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles William Cross

3. (b) Social Security Number

714-05-4601

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie In Cree

7. Birth date of deceased (mo., day, yr.) July 13 1884

8. AGE: Years 62 Months 6 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Summers Island Ind.
(Town, county, and state)

10. Usual occupation Watchman

11. Industry or business B & W Ry.

12. Name John Cross

13. Birthplace Ind.

14. Maiden name Billie Funga

15. Birthplace Ind.

16. Informant Mrs Bessie In. Cross
Address Hazen Rd.

17. Burial Date thereof Oct 11 '47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St Lukes Cem.

Location Summers Island Ind.

18. Funeral director Long's Stein Inc.

Address Summers Island Ind.

19. Oct. 11, 1947 J. P. Trupkin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 19 47, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-3- 19 44, to 2-8- 19 47, and that I last saw him alive on 1-26- 19 47.

Immediate cause of death acute coronary occlusion

Due to arteriosclerosis

Due to phlebotomy heart

Other conditions phlebotomy heart

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

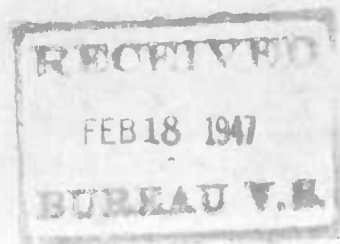
23. SIGNATURE W. H. Hines M.D. M. D. or other _____

Address 55 Seane St. Date signed 2-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

Mr. Leno Brinson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

01223

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lozacoring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 66 Douglas Ave
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Atlanta Poland Cutter

3. (b) Social Security Number

2

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband Jacob Cutter
6. (c) If alive, give age 4 years
7. Birth date of deceased (mo., day, yr.) Feb. 24, 1870
8. AGE: Years 76 Months 11 Days 27 It less than one day hrs. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual occupation Horsework
11. Industry or business Own home
12. Name Thos Poland
13. Birthplace Unknown
14. Maiden name Nettie M. Kenzie
15. Birthplace Unknown

16. Informant Mrs M. Raymond Clark
Address Detroit, Mich
17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Feb. 24, 1946
(month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Proctorburg, Ind
18. Funeral director M. Eichhorn
Address Lozacoring Ind
19. Feb. 24 19 47 Jannette M Boul
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21st 19 47 at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 47 to Feb 21 19 47
and that I last saw him alive on Feb 10 19 47
Immediate cause of death Cancer of stomach DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Henry B. Hodgson by 10 M. D. or other
Address Lozacoring Ind Date signed Feb 23 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 3 1947

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2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01224 40

DR. JOHNSON, JR.

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MineralCity or town RIDGELEY
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 JOHN ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MR. STEFANO DE STEFANO

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife JENNIE RICCIO6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) NOV. 6 18818. AGE: Years Months Days It less than one day
65 3 2 hrs. min.9. Birthplace ITALY
(Town, county, and state)10. Usual occupation RETIRED
Merchant

11. Industry or business

12. Name JOSEPH STEFANO13. Birthplace ITALY14. Maiden name Felicia DeSena
Italy

15. Birthplace

16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof Feb. 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)S. S. Peter & PaulsCemetery or crematory Cumberland, Md.Location Charles L. George
Cumberland, Md.

18. Funeral director

Address

19. Feb. 10, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 8, 1947 at 12:03 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30, 1947 to February 8, 1947
and that I last saw him alive on February 7, 1947Immediate cause of death Acute Infection, Colitis DURATION One week

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

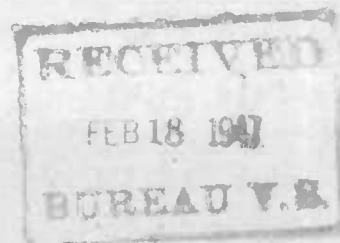
Means of Injury Injured at work?

23. SIGNATURE J. J. Johnson, M.D. M. D. or other
Address Cumberland, Md. Date signed 2-8-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

01225

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Years
Hospital, institution, or street address where death occurred:
Sylvan Retreat
How long in hospital or institution? 11 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Aaron A Dever

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Hannah Kimble
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 30 1860
8. AGE: Years 76 Months 6 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Jordons Run, Grant Co., West Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Angus Dever

13. Birthplace Virginia

14. Maiden name Hannah Kimble

15. Birthplace Grant Co., West Va

16. Informant Lester S. Dever

Address Rt, 3. Keyser, W. Va.

17. Burial Date thereof 2/15/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb. 15 19 47 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 19 47 at 1 P.M.

21. I CERTIFY that death occurred on the date stated; that I attended deceased from Dec. 3 19 46 to Feb. 12 19 47
and that I last saw him alive on Feb. 7 19 47

Immediate cause of death Acute myocardial failure
Due to Chronic myocarditis

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other _____

Address 1102 Centre St. Date signed 2-14-47

MARGIN RESERVED FOR BINDING

VS AT5 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1947

BUREAU V.S.

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: **Allegany**
 County.....
 City or town.....**Cumberland,**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution?.....**11 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland State.....**Allegany** County.....
 City or town.....**Rural Cumberland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**La Vale**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME
Robert Randall Dobson

3.(b) Social Security Number
None

4. Sex
Male
 5. Color or race
White
 6.(a) Single, married, widowed, or divorced
Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **Feb. 17, 1947**

8. AGE:
 Years **0** Months **0** Days **11**
 If less than one day
 hrs. min.

9. Birthplace **Cumberland, Md.**
 (Town, county, and state)
None

10. Usual occupation.....

11. Industry or business.....

FATHER
 12. Name.....**Francis J. Dobson**
 13. Birthplace.....**St. Paul Minn.**

MOTHER
 14. Maiden name.....**Anna May Randall**
 15. Birthplace.....**Sharon, Penna.**

16. Informant.....**Mrs. Francis J. Dobson**
 Address.....**Rural Cumberland, La Vale, Md.**

17. Burial Date thereof.....**Mar. 1, 1947**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....**Zion Memorial Cem.**
 Location.....**Cumberland, Md.**

18. Funeral director.....**H. Wayne George**
 Address.....**Cumberland, Md.**

19. (Date rec'd by registrar).....**March 1, 1947**
 Registrar.....**J. P. Frankish, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**Feb. 28, 1947** 1:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-17-47 to **2-28-47**
 and that I last saw him alive on **2-27-47**

Immediate cause of death.....**miscellaneous**
 DURATION

Due to.....**premature baby**

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

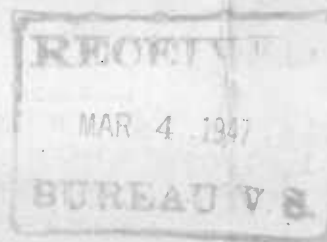
Means of injury..... Injured at work?

23. SIGNATURE.....**J. P. Frankish, M.D.**
 M. D. or other
 Address.....**59 Greene St.**
 Date signed.....**3-1-47**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01227
40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 107 Greene St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ellen Egan

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John S. Egan
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 8, 1860
 8. AGE: Years 86 Months 2 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

FATHER 12. Name Bernard O'Donnell
 13. Birthplace Maryland
 MOTHER 14. Maiden name Mary Broderick
 15. Birthplace Ireland

16. Informant Mrs. Wm. G. Beier
 Address 107 Greene St. Cumberland, Md.

17. Burial Date thereof Feb. 24, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Patricks Cem.
 Location Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

19. Feb. 22, 1947 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1947, at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-11-47 19____ to 2-20-47 19____
 and that I last saw her alive on 2-20-47 19____

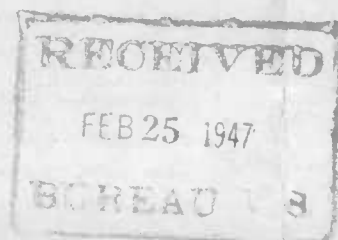
Immediate cause of death	DURATION
<u>Hypostatic Pneumonia</u>	<u>3 da.</u>
<u>Laceration scalp</u>	<u>9 da.</u>
Due to _____	_____
Due to _____	_____
Other conditions _____	_____
(Include pregnancy within 3 months of death)	

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 2-11-47
 Where did injury occur? Cumberland, Allegany, Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury Fell down steps Injured at work? no

23. SIGNATURE [Signature] M. D. or other _____
 Address Cumberland, Md. Date signed 2-22-47



FEB 25 1947

BUREAU 3

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

C12285

450

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 528 Louisiana Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William C. Fier

3. (b) Social Security Number

214-05-9304

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Isabelle Nesbitt6. (c) If alive, give age 60 years

7. Birth date of

deceased (mo., day, yr.)

March 2 1886

8. AGE:

Year

Months

Days

If less than one day

60116

hrs.

min.

9. Birthplace

Barton, Allegany Co., Maryland

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Cellenese Corp

FATHER

12. Name

William Fier

13. Birthplace

Barton, Md.

MOTHER

14. Maiden name

Anna Davis

15. Birthplace

England

16. Informant

T Victor FierAddress 528 Louisiana Ave, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/11/47

(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Feb 11 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 7.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947 to 1947and that I last saw him alive Dead Feb. 8 1947

Immediate cause of death

Chronic Myocarditis

DURATION

several
years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

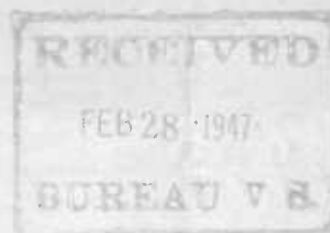
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 2-8-47



2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

01228

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. JOHNSON

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 HENDERSON AVENUE
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

MRS. BESSIE GATRELL

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6. (b) Name of husband or wife CHARLES W. GATRELL

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 12, 1881

8. AGE: Years 65 Months 1 Days 28
If less than one day hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WALTER STANLEY

13. Birthplace VIRGINIA

14. Maiden name ELIZABETH WEBSTER

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Feb. 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lukes

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Feb 12 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 10 1947 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946 to February 10, 1947

and that I last saw him alive on February 9, 1947

Immediate cause of death

Tubercular Pneumonia DURATION One week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D.

M. D. or other

Address Cumberland, Md. Date signed Feb 10 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 18 1947
BUREAU V.B.

2-35-

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01230

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.#3 Bedford Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#3 Bedford Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Louis Gearhart

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Anna Lohr Gearhart

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan. 30, 1854

8. AGE:

Years 93

Months 0

Days 6

It less than one day

hrs. min.

9. Birthplace

Manor Hill, Penna.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farmer

FATHER

12. Name

Cyrus Gearhart

13. Birthplace

Penna.

MOTHER

14. Maiden name

Mary Snyder

15. Birthplace

Penna.

16. Informant

Mrs. Wm. E. Kniseley

Address

R.D.#3 Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 9, 1947

(month) (day) (year)

Cemetery or crematory

Graef's Cemetery

Location

Cairnbrook, Penna.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. (Date rec'd by registrar)

Feb. 7, 1947

19. (Date signed)

Feb. 7, 1947

Dr. O. L. Franklin
M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 6,

19 47

at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 5,

19 47

to Feb. 6,

19 47

and that I last saw him alive on Feb. 5,

19 47

Immediate cause of death

Myocardial

DURATION

Regeneration

Contributory Cause - Prostatitis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. O. L. Franklin

M. D. or other

Address 122 Bedford St. Cumberland

Md.

Date signed Feb. 7, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County..... Memoral Hospital
City or town..... Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 6 days
Hospital, institution, or street address where death occurred..... Memoral Hospital
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Allegany
City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 162 Baltimore St.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

T. Edward T. Halley

3. (b) Social Security Number

214-05-6632

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male..... White..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years

May 15 1873

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

73..... 8..... 25.....

9. Birthplace..... Pa.
(Town, county, and state)

10. Usual occupation..... Ticket Taker

11. Industry or business..... Strand Theatre

12. Name..... Thomas Halley

13. Birthplace..... Md

14. Maiden name..... Emma Eskin

15. Birthplace..... Pa

16. Informant..... Everlan. Reynolds

Address..... Cumberland Md

17. (Burial, cremation, or removal. Which?)..... Date thereof..... (month) (day) (year)

Burial..... Feb. 13 1947

Cemetery or crematory..... Rose Hill Cemetery

Location..... Cumberland Md

18. Funeral director..... John C. Wolford

Address..... Cumberland Md

19. (Date rec'd by registrar)..... Feb. 13 1947

Registrar..... J. V. Kaufman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 10 1947 at 8:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 5 1947 to Feb. 10 1947

and that I last saw h..... alive on Feb. 10 1947

Immediate cause of death.....

Asphyxia

Amnesia

Due to.....

Brucellosis

Due to.....

Myocardial infarction

Other conditions.....

Myocardial infarction

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Samuel J. Prosser

M. D. or other

Address.....

Date signed..... 2/14/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01231

RECEIVED

FEB 18 1947

BUREAU V.M.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

01232

Reg. Dist. No. 45

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Allegheey
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheey
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 60 Marion
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Frances Hardin

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Raye Hardin

7. Birth date of

deceased (mo., day, yr.)

November 5 1883

6. (c) If alive, give age..... years

8. AGE:

Years 61 Months 2 Days 29 It less than one day
hrs. min.

9. Birthplace

Hyndman Bedford Co. Pa
(Town, county, and state)

10. Usual occupation

House

11. Industry or business

Jacob "Lowery"

12. Name

Hyndman Pa

13. Birthplace

Mary Berneen

14. Maiden name

Hyndman Pa

15. Birthplace

Paul Hardin

16. Informant

360 Bedford St Cumberland Md

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) day (year)

Cemetery or crematory

Zion Memorial Cem

Location

Cumberland Md

18. Funeral director

William H. Right

Address

Cumberland Md19. Feb. 7 19 47

(Date rec'd by registrar)

J. P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 4 1947 at 12:45 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

February 3 1947 to February 4 1947and that I last saw him alive on Feb. 4 19 47

Immediate cause of death

Acute myocardial infarction

DURATION

6 hrs?

Due to

Coronary atherosclerosis

Due to

Myocardial infarction

Due to

Coronary artery diseaseOther conditions Chronic pulmonary disease(Emphysema)

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Samuel Jacobson M. D. or otherAddress 1511 E. 1st St Date signed 2/4/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1947
BUREAU
7-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

★ 01233

Reg. Dist. No. 90

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 121 Park Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Infant

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

3 28 hrs. min.

9. Birthplace Frostburg, Allegheny, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)Date thereof 2-10-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-10-47
(Date rec'd by registrar)19. 47 Mrs. Nancy Al Roe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 19 47 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 5 19 47 to Feb 8 19 47
and that I last saw her alive on Feb 5 19 47

Immediate cause of death

Broncho Pneumonia
(Primary)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

WOM Lane Jr MD
Frostburg Md M. D. or other
Address Date signed 2-8-47

RECEIVED

FEB 12 1947

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-6

01234

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
Allegheny Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegheny
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1371 Waverly Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Harry Thomas Henry

3.(b) Social Security Number

705-05-4462

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Bessie C. Henry
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 10 - 1895

8. AGE: Year 61 Months 10 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Brossius, Morgan, W. Va.
(Town, county, and state)

10. Usual occupation Platform Foreman

11. Industry or business B & O Freight Station

12. Name Chas. D. Henry

13. Birthplace Berkeley Springs W. Va.

14. Maiden name Elizabeth M. Shael

15. Birthplace Berkeley Springs W. Va.

16. Informant Mrs. Harry Henry

Address 1371 Waverly Terrace, Chamberland, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb 17, 1947
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Chamberland

18. Funeral director John D. Hafer

Address Chamberland, Md.

19. Feb 17, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1947, at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 to 2-14-47 and that I last saw him alive on 2-13-46

Immediate cause of death Bonti's Disease DURATION 1 1/2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Splenomegaly Date of op. 1-1-47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

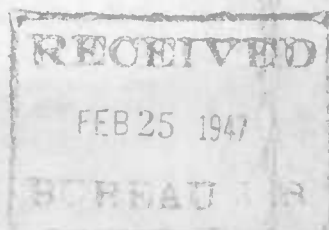
23. SIGNATURE [Signature] M. D. or other

Address [Signature] Date signed 2-15-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

01235 40
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumtburland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
202 Maple St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumtburland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 Maple St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Marion Elizabeth Hoover
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Abraham S. Hoover
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 22 1874
8. AGE: Years 72 Months 10 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Cumtburland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name James Lancaster

13. Birthplace Md.

14. Maiden name Elizabeth B. Kinsie

15. Birthplace Md.

16. Informant Shannon Hoover

Address Cumtburland

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Feb 28 47
(month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumtburland

18. Funeral director John's Station Inc

Address Cumtburland

19. Feb 27 19 47 J. P. Trautkin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 47 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/24/47 19 to 2/25/47 19
and that I last saw him/her alive on 2/25/47 19

Immediate cause of death Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

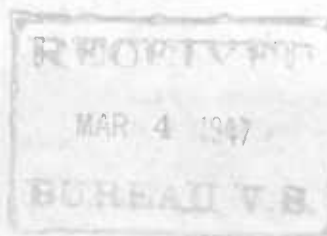
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mans of injury _____ Injured at work?

23. SIGNATURE R. P. Mulholland M. D. or other

Address Cumtburland Date signed 2/26/47



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01236

Reg. Diat. No. 20

1. PLACE OF DEATH:

County Allegheny
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hrs
 Hospital, institution, or street address where death occurred:
Star Route, Flintstone Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Allegheny County Allegheny
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Albert Innes

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sadie Sommerville
 6. (c) If alive, give age 72 years
 7. Birth date of deceased (mo., day, yr.) Oct 31, 1873

8. AGE: Years 73 Months 3 Days 22 If less than one day
 hrs. min.

9. Birthplace Chaneyville, Bedford Co, Pa
 (Town, county, and state)

10. Usual occupation Off Bear

11. Industry or business Saw Mills

12. Name Alvin Innes

13. Birthplace Chaneyville Pa

14. Maiden name Ollie Murphy

15. Birthplace Chaneyville Pa

16. Informant Benjamin Innes

Address Flintstone, Cumberland Mt

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 26, 1947
 (month) (day) (year)

Cemetery or crematory Brother Cemetery

Location Flintstone, Md

18. Funeral director John J. Hafner

Address Cumberland Md

19. Feb 25, 47 Nina R. Bander
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1947, at 10:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb 23 1947
 and that I last saw him alive on Feb. 23 1947

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to hypertension ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Watson, M.D. M. D. or other

Address Little Orleans, Md Date signed 2/24/47

RECEIVED
FEB 28 1947
BUREAU OF
1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

01237

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 83 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Sarah Robinson Inskeep

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Othe Inskeep
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 3, 1863

8. AGE: Years 83 Months 11 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Barton, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own Home

12. Name Robert Russell
 13. Birthplace Scotland

14. Maiden name Jean Scot Anderson
 15. Birthplace Scotland

16. Informant Mr Robert Inskeep
 Address Barton, Maryland

17. Burial Date thereof Feb 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland
Ellsworth S. Boal

18. Funeral director _____
 Address Westernport, Maryland

19. Feb 25 19 47 W. S. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 19 47 at 1:25 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb - 23 19 47 to Feb 23 19 47
 and that I last saw him alive on Feb 23 19 47

Immediate cause of death Cerebral Thrombosis DURATION 1 hr

Due to Ch. Myocarditis
arteriosclerosis

Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

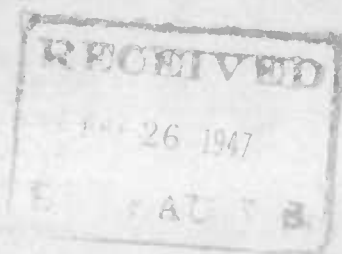
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. S. Boal M. D. or other _____

Address Westernport MD Date signed 2/25/47



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

01238

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months
Hospital, institution, or street address where death occurred:
Railroad St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 Railroad St.
(If rural, give LOCATION)
2. (a) If veteran, name war World War II

3. (a) FULL NAME

Carl Joseph Kearney

3. (b) Social Security Number

213-22-4653

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 23, 1926

8. AGE: Years 20 Months 11 Days 14 If less than one day hrs. min.

9. Birthplace Westernport-Allegany-Md
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Radio Store

12. Name Carl E. Kearney

13. Birthplace Westernport Md.

14. Maiden name Oliver Boyce

15. Birthplace W. T. Milled, Md.

16. Informant Carl E. Kearney Jr.

Address Shallmar, Md.

17. Burial (Burial, cremation, or removal Which?) Feb 20 47
(month) (day) (year)

Cemetery or crematory Philom. Cp.

Location Westernport Md.

18. Funeral director Ellsworth & Sons

Address Westernport, Md.

19. Feb 19 47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 16 to 19 17

and that I last saw him DEAD Feb 17 1947

Immediate cause of death Exposure DURATION 12 hrs

Due to Fell from Co. P. R. R. bridge

to bed of Potomac river near bank

Due to at Westernport, Md.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-16/47

Where did injury occur? Westernport Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Fell off Co. P. R. R. bridge

Means of injury Unconscious from Injured at work?

Deputy Medical Examiner Allegany

23. SIGNATURE W. D. Drumm Md. M. D. or other

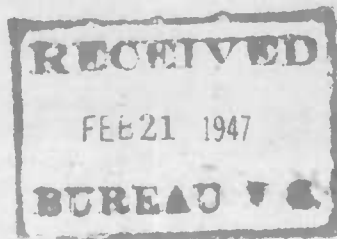
Address Cambridge Md. Date signed 2-17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 60

01239

1. PLACE OF DEATH:

County AlleganyCity or town Rural near Dawson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Rural near Dawson
(If outside city or town limits, write RURAL and give nearest town)Street No. R#3 Keyser, W. Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jacob Howe Keplinger

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Rosetta Harper6. (c) If alive, give age 72 years

7. Birth date of

deceased (mo., day, yr.)

Feb. 25, 1878

8. AGE:

Years

Months

Days

If less than one day

68116

hrs.

min.

9. Birthplace

Grant Co. W. Va.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Andrew Keplinger

13. Birthplace

Virginia

MOTHER

14. Maiden name

Phoebe Davis

15. Birthplace

Pendleton Co. W. Va.

16. Informant

Mrs. Rosetta H. Keplinger

Address

R#3, Keyser, W. Va.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Queenspoint

Location

W. Va.

18. Funeral director

N.H. Rogers

Address

Keyser, W. Va.

19.

(Date rec'd by registrar)

19.

Feb. 6 1947
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 3, 1947, at 7 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 3, 1947, to Feb. 7, 1947
and that I last saw him alive on Feb. 3, 1947, last seen 2 months previouslyImmediate cause of death Coronary Thrombosis

DURATION

Short
Sudden

Due to

myocarditis chronic

Due to

Hypertension chronic

Other conditions

arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blasppin MD

M. D. or other

Address Keyser, W. Va. Date signed 2-4-47

RECEIVED

FEB 7 1947

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *93-1*

01240

CERTIFICATE OF DEATH

Reg. Dist. No. *43*

1. PLACE OF DEATH:

County *Allegany*
City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegany*City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)Street No. *226 Williams St.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George P. Earl Ketzner

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

*Widowed*6. (b) Name of husband or wife *Irene Cooley Ketzner*

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug. 9, 1894*

8. AGE:

Years

Months

Days

If less than one day

*52**5**24*

hrs.

min.

9. Birthplace *Harpers Ferry, W. Va.*
(Town, county, and state)10. Usual occupation *Freight Conductor*11. Industry or business *New York Central R.R. Co.*12. Name *John Ketzner*13. Birthplace *Harpers Ferry, W. Va.*14. Maiden name *Georgianna Forney*15. Birthplace *Va.*16. Informant *Mr. Ralph Ketzner*Address *226 Williams St. Cumberland, Md.*17. Burial Date thereof *Feb. 6, 1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *I.O.O.F. Cemetery*Location *Blanchester, Ohio.*18. Funeral director *Charles L. George*Address *Cumberland, Md.*19. *Feb. 5* 19 *47* *J. L. Franklin M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 4,* 19 *47* at *12:20 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mardi 19 *Feb. 4* to *Feb. 4* 19 *47*and that I last saw him alive on *Feb. 4* 19 *47*Immediate cause of death *Myocarditis*

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. L. Franklin M.D.* M. D. or otherAddress *Cumberland, Md.* Date signed *2-4-47*

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 11 1947
SCHMIDT & B

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

01241

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH ALLEGANY

County CUMBERLAND, MD.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. ALLEGANY COUNTY INFIRMARY (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. BARTLEY KILROY

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife MRS. BRIDGES (TOWN) KILROY

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCTOBER 23 1875

8. AGE:

71

Years

Months

4

Days

4

If less than one day

hrs.

min.

9. Birthplace

WEST VIRGINIA

NONE

10. Usual occupation

11. Industry or business

FATHER

12. Name

THOMAS KILROY

13. Birthplace

IRELAND

MOTHER

14. Maiden name

MARGARET SPEIGLER Rowan

15. Birthplace

PENNSYLVANIA

16. Informant

Elizabeth Kilroy

Address 619 Mill St, Wilkensburg 21, Pa

17. Burial (Burial, cremation, or removal. Which?)

Burial

Date thereof

3/1/47

(month) (day) (year)

Cemetery or crematory

St Phillip & James Cemetery

Location

Meyersdale Pa.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Mar 1 1947 (Date rec'd by registrar)

19. 47

J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

FEBRUARY 27, 1947 5:00 A.M.

20. DATE OF DEATH 19. at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 3 19. to Feb. 27 19. 47

and that I last saw him alive on Feb. 26 19. 47

Immediate cause of death

DURATION

Myocardial failure

Due to Hypertrophy prostate & urinary retention

Due to Scurvy

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

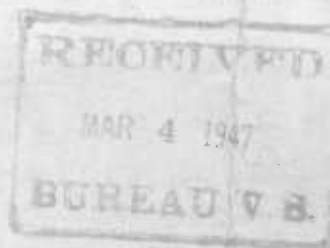
Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

Address 110 S. Centre St. Date signed 2-27-47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01242

5

450

1. PLACE OF DEATH:

County Allegany
City or town Cumberland (near)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Highway near main gate of Celanese Corp. of Am.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 427 Walnut
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Emil Henry Krampf

3.(b) Social Security Number

220-07-6822

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Nannie Berry Krampf

5.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 25 1881

8. AGE: Years Months Days If less than one day
65 8 27hrs.min.

9. Birthplace Westernport, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business Celanese Corp of America

12. Name Peter Krampf

13. Birthplace Germany

14. Maiden name Katherine Earnfield

15. Birthplace Germany

16. Informant Mrs. E. H. Krampf

Address 427 Walnut St, Cumberland, Md.

17. Burial Date thereof 2/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb. 25, 47 Registrar W. H. Kight
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 19 47 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive Dead Feb. 22 19 47

Immediate cause of death Angina Pectoris about 4 years DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Medical Examiner Allegany Co. Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 2-23/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 28 1947
BUREAU V S.

1-36

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01243

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? Ten days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Joe Lantz

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) October 5, 1866

8. AGE: Years 80 Months 4 Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Noah Lantz

13. Birthplace West Virginia

14. Maiden name Mary Sever

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Feb 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bloomington Cemetery

Location Bloomington, Md.

18. Funeral director Ellsworth School

Address Wintersport, Md.

19. Feb 9, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1947 11:35A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-28- 1947 to 2-7- 1947

and that I last saw him alive on 2-6- 1947

Immediate cause of death Arteriosclerosis

DURATION

Due to _____

Due to _____

Other condition Benign hepatomegaly

chronic nephritis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

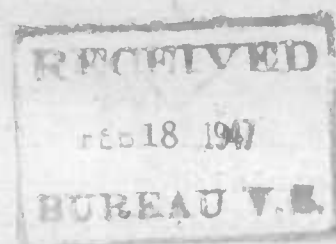
23. SIGNATURE Howard P. Polson, M.D.

Address Cumberland, Md. Date signed 2-8-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01244

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 732 Baker St.
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

William M. Leckemby

3. (b) Social Security Number

715-18-7741

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried

6. (b) Name of husband or wife

Emma Tharp

5. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 19028. AGE: Years Months Days If less than one day
44 21 11 hrs. min.9. Birthplace Kennelsville Bedford Co Pa
(Town, county, and state)10. Usual occupation Bx Railroad Brakeman

11. Industry or business

12. Name William M. Leckemby13. Birthplace Penn.14. Maiden name Orla Kennell15. Birthplace Kennelsville16. Informant Mrs. Dale KippAddress Hyndman, Pa.17. Burial Date thereof Feb. 25 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hyndman, Pa.Location Hyndman, Pa.18. Funeral director Hyndman, Pa.Address Hyndman, Pa.19. Feb. 24 47 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 19 47 at 9.25 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to 19 47
and that I last saw him alive Dead Feb. 21 19 47

Immediate cause of death

Lobar Pneumoniaabout 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Consolidation, apex right lung
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

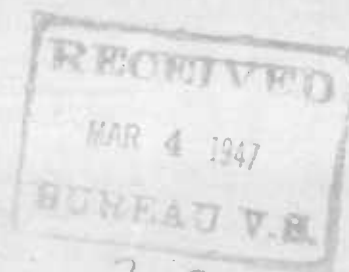
Means of injury Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 2-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

1. PLACE OF DEATH:

County Allegheny

City or town Cambria

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegheny Hospital

How long in hospital or institution? about 3 mths

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME Garrett John Luterman

3. (b) Social Security Number None

4. Sex Male

5. Color of race White

6. (a) Single, married, widowed, or divorced Widowed.

6. (b) Name of husband or wife Anna Luterman

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) 27 Feb 1860

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>78</u>	<u>-</u>	<u>-</u>
		hrs.	min.

9. Birthplace Oldtown, Md

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business -

FATHER

12. Name Randolph Luterman

13. Birthplace Md.

MOTHER

14. Maiden name Evelyn Trigg

15. Birthplace Md.

16. Informant J. D. Myers

Address Oldtown, Md.

17. Burial Date thereof Mar 1 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anthon Cemetery

Location Bridgeville, Pa.

18. Funeral director Louis Stein, Inc.

Address Cambria, Md.

19. Feb. 28 19 47 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1947 at 12:22 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Feb. 27 1947, and that I last saw him alive on February 27 1947

Immediate cause of death Carcinoma of stomach years.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

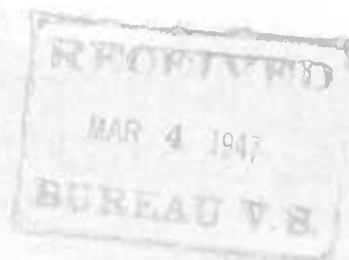
Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D.

M. D. or other

Address 41 Greene St Date signed Feb 27/47

Mr Schindler



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-0

01246

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleghenyCity or town Green Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County HampshireCity or town Green Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Fannie L. Lyons

3. (b) Social Security Number

None4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Tony Lyons

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 30 18998. AGE: Years 47 Months 3 Days 23 If less than one day _____ hr. _____ min.9. Birthplace W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name B. F. Twigg13. Birthplace Ind. Va.14. Maiden name Catherine Foley15. Birthplace Ind. Va.16. Informant Tony LyonsAddress Green Springs W. Va.17. Burial Date thereof 20/25/47
(Burial, cremation, or removal) (Which?) (month) (day) (year)Cemetery or crematory Camp HillLocation Paw Paw W. Va.18. Funeral director Louis Shriv In.Address Cumberland, Md.19. Feb. 25 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1 19 46 to Feb 22 19 47and that I last saw him alive on Feb 22 19 47Immediate cause of death Cerebral Thrombosis[E.M.D.O.I.S.W.]DURATION 3 dayDue to Carcinoma of CervixDue to 12/1

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. P. Franklin, M.D.Address Cumberland, Md.Date signed Feb 4/47

RECEIVED
MAR 4 1947
BUREAU V.S.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-R

CERTIFICATE OF DEATH

01247

Reg. Diat. No. 40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 640 N. Mechanic St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Martin

3. (b) Social Security Number

None4. Sex ? 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 19478. AGE: Years Months Days If less than one day
hrs. 45 min.9. Birthplace Cumberland, Allegheny, Md.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Joseph Martin13. Birthplace Windsor, Pa.14. Maiden name Roma Venning15. Birthplace England16. Informant Joseph MartinAddress Cumberland, Md.17. Burial Date thereof February 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John the Baptist CemeteryLocation New Baltimore, Md.18. Funeral director John J. HaferAddress Cumberland, Md.19. Feb 17 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1947 at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 16 47 Feb. 16 47
and that I last saw him/her alive on Feb. 16 47

Immediate cause of death

DURATION

Congenital malformation -
of external genitalia.

Due to

Other conditions Complete atelectasis of lungs.

(Include pregnancy within 8 months of death)

Major findings of operations

Report will follow

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. P. Hodges, M.D.
Cumberland, Md. Date signed 2/18/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1947

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

01248

9

1. PLACE OF DEATH

County... AlleganyCity or town... Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

181 Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... AlleganyCity or town... Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 181 Broadway
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Mr. Ed. Maurey

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Oct. 25 - 1901

8. AGE:

Years

Months

Days

If less than one day

44 3 17 hrs. min.9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)10. Usual occupation Sales manager

11. Industry or business

12. Name Joseph J. Maurey13. Birthplace Frostburg, Md.14. Maiden name Maurey15. Birthplace Cornington, Ky.16. Informant Mr. Giles MaureyAddress 181 Broadway, Frostburg17. Burial, cremation, or removal, Which? BurialDate thereof 2-4-1947
(month) (day) (year)Cemetery or crematory St. Michael's Cem.Location Frostburg, Md.18. Funeral director Joseph J. MaureyAddress 76 Frostburg, Md.19. 2-3 47 Ms. Maurey N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 47 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to 19 47 and that I last saw him in Dead Feb 2 19 47

Immediate cause of death

Chronic alcoholism

DURATION

2 days

Due to

Due to

Other conditions

Found dead in jail cell at Frostburg, Md.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Deputy Medical Examiner Injured at work? Allegany Co.

23. SIGNATURE

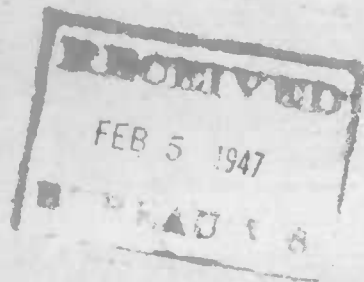
H. V. Deming, M.D. M. D. or otherAddress Cumberland, Md. Date signed Feb 2/47

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

338 M



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01249

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 9 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 228 Glenn St
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John Vincent May

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Child

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug 30, 1945

8. AGE:

Years

Months

Days

It less than one day

153

hrs.

min.

9. Birthplace

Cumberland, Allegany Co, Md

(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

FATHER

12. Name

Western May

13. Birthplace

Timber Ridge W. Va

MOTHER

14. Maiden name

Sullivan A Sager

15. Birthplace

Cumberland

16. Informant

Western May

Address

228 Glenn St - Cumberland Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb - 5, 1947

Cemetery or crematory

St Peter's & Paul Cthl Cn

Location

Cumberland Md

18. Funeral director

John J. Hafer

Address

Cumberland

19.

(Date rec'd by registrar)

Feb 519J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1947, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 2 1947 to Feb 3 1947

and that I last saw h..... alive on..... 19.....

Immediate cause of death

pneumonia

DURATION

2 days

Due to

pneumoniamuscle

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. King (H)

M. D. or other

Address

59 Lane DrDate signed 2-5-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten text, possibly a name or address, mostly illegible due to fading.

Handwritten text, possibly a name or address, mostly illegible due to fading.

Handwritten text, possibly a name or address, mostly illegible due to fading.

Handwritten text, possibly a name or address, mostly illegible due to fading.

RECEIVED
FEB 11 1947
BUREAU 7 8
2-357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

★ 0125040
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 yrs.
 Hospital, institution, or street address where death occurred Memorial Hospital
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 404 1/2 N. Center St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

V.
Harry Mentzer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Uletha Harens
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 21 1868
 8. AGE: Years 78 Months 6 Days 11 If less than one day..... hrs. min.

9. Birthplace Indiana
 (Town, county, and state)
 10. Usual occupation Painter & Paper Hanger
 11. Industry or business Retired 15 yrs
 12. Name Daniel Mentzer
 13. Birthplace Indiana
 14. Maiden name Louisa Coblentz
 15. Birthplace Indiana

16. Informant French Sensabarger
 Address Cumberland
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 3 47
 (month) (day) (year)
 Cemetery or crematory Ligonier Cem.
 Location Ligonier - Holt Co. Indiana
 18. Funeral director Louis Stein Inc
 Address Cumberland
 19. Feb 3 19 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 19 47 at 9.22 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him Dead Feb 2 19 47
 Immediate cause of death.....
Pulmonary hemorrhage
 DURATION 1.1/2
hours
 Due to Crushed chest, several
fractured ribs.
 Due to Jumped out of 3rd. story
window at Memorial Hospital
 Other conditions Fractured skull & pelvis
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of 2.2.47
 Where did injury occur? Cumberland Allegany Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Memorial Hospital
 Means of injury As above Injured at work? no
 23. SIGNATURE H. V. Deming, M.D. H. V. Deming, M.D.
 M. D. or other
 Address Cumberland Md. Date signed 2/3/47



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-d

CERTIFICATE OF DEATH

Reg. Diat. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, R.D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. 301, Box 101
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Daniel Edward Middleton

3. (b) Social Security Number

214-05-9682V

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nettie Middleton
 6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 11, 1889

8. AGE: 57 Years 10 Months 16 Days If less than one day hrs. min.

9. Birthplace Frostburg, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Attendant

11. Industry or business Service Station

12. Name Alex. Middleton

13. Birthplace West Virginia

14. Maiden name Matilda Holt

15. Birthplace West Virginia

16. Informant Mrs. Daniel Middleton

Address Frostburg, Md.

17. Burial Date thereof Mar 1, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director J. R. Ourst

Address Frostburg, Md.

19. 2-28 19. 47 Mrs. Nancy H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947, at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19. Feb 27 19. 47
 and that I last saw him alive on Feb 26 19. 47

Immediate cause of death Chs Myocarditis
 DURATION several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wm McLane Jr MD
 M. D. or other

Address Frostburg, Md. Date signed Feb 27 1947

RECEIVED

MAR 3 1947

BUREAU V B.

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

01252

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Spring Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jacob Miller

3. (b) Social Security Number

214-07-1704

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

maleWhitemarried6. (b) Name of husband or wife Rose Miller

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 26 1879

8. AGE:

Years

Months

Days

If less than one day

67927

hrs.

min.

9. Birthplace Barton Co. W. Va.
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

12. Name Jacob Miller13. Birthplace W. Va.14. Maiden name Amenda Foreman15. Birthplace W. Va.16. Informant Rose MillerAddress Cumberland Md17. Burial Date thereof Feb 26 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter + Pauls ChLocation Cumberland Md.18. Funeral director Loris Stein, IncAddress Cumberland Md.19. Feb 26 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 19 47 at 9:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 19 47 to Feb. 23 19 47and that I last saw him alive on Feb. 22 19 47

Immediate cause of death

Lobar Pneumonia

DURATION

3 weeks

Due to

Due to

Other conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

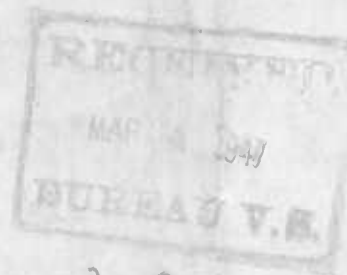
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland, Md Date signed 2-23-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 29-6

CERTIFICATE OF DEATH

01253

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 years
Hospital, institution, or street address where death occurred:
Bedford Road, Rt. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bedford Road, R.F.D. #3
(If rural, give LOCATION)
2(a) If veteran, name war Gr

3. (a) FULL NAME

Mary Ellen Monahan

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John Monahan

6. (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) August 25, 1856

8. AGE: Years 90 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Own home

12. Name Hugh Francis

13. Birthplace Ireland

14. Maiden name Margaret Gallagher

15. Birthplace Ireland

16. Informant Mrs. Raymond Ackerson

Address Bedford Road, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 25, 1947
(month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Wrothburg, Ind.

18. Funeral director W. Eichhorn

Address W. Eichhorn, Ind.

19. Feb 25 19 47 J. P. Agushin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 19 47 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Feb 22 19 47

and that I last saw her alive on Feb 7 19 47

Immediate cause of death and G.H. myocarditis; one month

Due to La Grippe

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

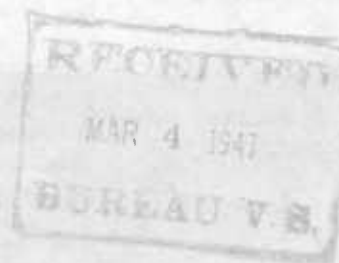
23. SIGNATURE T. Bailey Hunter M.D. M. D. or other

Address Cumberland, Md. Date signed 2/24/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 90

01254

1. PLACE OF DEATH:

County AlleghenyCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. Rd. No. 1
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Patrick Alessius Monahan

3. (b) Social Security Number

213-18-2036

4. Sex

male

5. Color or race

white married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Emma Rejice6. (c) If alive, age 64 years7. Birth date of deceased (mo., day, yr.) June 26th. 1880

8. AGE:

Years 66 Months 5 Days 12 hrs. min.9. Birthplace Frederick, Alleg. Md.
(Town, county, and state)10. Usual occupation Retired miner11. Industry or business Coal Mines12. Name John Monahan13. Birthplace Ireland14. Maiden name Mary Freal15. Birthplace Ireland16. Informant Mrs. Bern. SeibertAddress Rd. 1 Frederick17. Burial Burial Date thereof 2-10-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michael'sLocation Frederick, Md.18. Funeral director Jacob DafferAddress Frederick, Md.19. 2-10 19 47 Wm. H. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 19 47 at 6:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 19 46 to Feb 8 19 47and that I last saw him alive on Feb 3 19 47Immediate cause of death Chronic myocarditis DURATION several months

Due to

Due to

Other conditions asthma

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Rae M. D. or otherAddress Frederick Md Date signed 2-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 12 1947

BUREAU V. S.

1-35

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-d

CERTIFICATE OF DEATH

Reg. Diat. No. 0125540

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 Years
Hospital, institution, or street address where death occurred:
Spring Gap (Residence)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Spring Gap
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

James Robert Mullenax

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Fannie Teter
6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 4 1878
8. AGE: Years 68 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace Monterey, Highland Co., Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name Jacob Mullenax

13. Birthplace Monterey, Va.

MOTHER 14. Maiden name Rebecca Simmons

15. Birthplace Monterey, Va.

16. Informant Lester Mullenax

Address Spring Gap Maryland

17. Burial Date thereof 2/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oldtown Cemetery

Location Oldtown, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb. 16 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947 at 2-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9 1947 to Feb. 9 1947
and that I last saw him alive on Feb. 9 1947

Immediate cause of death

Coronary Thrombosis DURATION 12 hrs.
Due to hypertension C. V. Disease (?)
Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE B. M. Schindler M. D. or other

Address 41 Green St. Cumberland, Md. Date signed Feb. 12, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 18 1947
BUREAU V.R.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 746

CERTIFICATE OF DEATH

Reg. Dist. No. 01256 40

1. PLACE OF DEATH:

County AlleghenyCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 115 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Randolph Alonzo Norris

3. (b) Social Security Number

212-24-1383

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 18948. AGE: Years 52 Months 2 Days 1 If less than one day hrs. min.9. Birthplace Brunswick Md.
(Town, county, and state)10. Usual occupation Janitor11. Industry or business General Work12. Name Henry E. Norris13. Birthplace Little Orleans, Md.14. Maiden name Anne B. Zimmermann15. Birthplace Cambridge Md.16. Informant Mr. Wilbert E. BrightAddress 206 Va Ave - Camb. Md.17. Burial Date thereof Feb 6, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fidelfort CemeteryLocation Cambridge Md.18. Funeral director John J. HoyerAddress Cambridge Md.19. Feb. 5, 1947 J. P. Tankin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3, 1947 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1947 to Feb 3, 1947
and that I last saw him alive on Feb 3, 1947Immediate cause of death Pneumonia

DURATION

Due to

Due to

Other conditions Asthma

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Kester M. D. or otherAddress 121 Bedford St Date signed 2/5/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

112 N. Westmore St
Cincinnati, Ohio

112 N. Westmore St
Cincinnati, Ohio

March 15-25-51
Also white sample

RECEIVED
FEB 25 1951
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Diat. No. 01257

1. PLACE OF DEATH:

County Allegheny
 City or town Ligonier, Pa.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 67 years
 Hospital, institution, or street address where death occurred: Rockville St.
 How long in hospital or institution? L

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Ligonier, Pa.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rockville St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war L

3. (a) FULL NAME

Euphemia Chalmers Patton

3. (b) Social Security Number

L4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband Robert Patton7. Birth date of deceased (mo., day, yr.) Feb 14, 18558. AGE: 91 Years 11 Months 19 Days L If less than one day hrs. min.9. Birthplace Larkhall, Scotland
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name Unknown13. Birthplace Scotland14. Maiden name Unknown15. Birthplace Scotland16. Informant Mrs. Bessie GilbeckAddress Ligonier, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 6, 1947
(Month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Ligonier, Md.18. Funeral director J. M. EckhornAddress Ligonier, Md.19. Feb 6 1947 Janet M. Coal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1947 at 7 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1st 1947 to Feb 3rd 1947 and that I last saw her alive on Feb 2nd 1947Immediate cause of death Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kenny Dr. Hodgeson M.D.Address Ligonier, Md. Date signed Feb. 5th 47

RECEIVED
JUL 11 1947
BUREAU V.R.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-0

01258

CERTIFICATE OF DEATH

Reg. Dist. No. 40

DR. HODGES

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND, MARYLAND.
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 SOUTH WAVERLY TERRACE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY PENCE

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITESINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth data of

deceased (mo., day, yr.)

FEB. 4, 1947

8. AGE:

Years

Months

Days

If less than one day

2 DAYSFEB.

hrs.

min.

9. Birthplace CUMBERLAND ALLEGANY MARYLAND.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name ROBERT PENCE13. Birthplace OKLAHOMA

MOTHER

14. Maiden name ADA WHITE15. Birthplace W. VA.16. Informant ROBERT PENCEAddress CUMBERLAND, MD.17. BURIAL & Removal Date thereof 2/7/1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BLUEMONT, CEME.Location GRAFTON, WEST VA.18. Funeral director LOUIS STEIN, INC.Address CUMBERLAND, MD.19. Feb 6 1947
(Date rec'd by registrar)

Registrar

23. SIGNATURE

Address Cumberland, MD. Date signed 2/6/47

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1947, at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 1947 to Feb 6 1947
and that I last saw him alive on Feb 6 1947

Immediate cause of death

Prematurity
of placenta
Due to premature separation
Due to of placenta

DURATION

7 1/2 m

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 11 1947
BUREAU V E

-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-a

CERTIFICATE OF DEATH

Reg. Dist. No. 40

R. R. WILLIAMS

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL

How long in hospital or institution? 100 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 48 VIRGINIA AVE.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EMMA. VIRGINIA PIERCE

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1858

8. AGE: Years Months Days If less than one day
88 4 11 hrs. min.9. Birthplace Near Old Town, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name JOHN PIERCE

13. Birthplace Unknown

14. Maiden name ATHEY Rebecca A.

15. Birthplace Unknown

16. Informant J. Lewis Pierce Jr.

Address 42 Va. Ave. Cumberland, Md.

17. Burial Date thereof Feb. 7, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Feb 7 1947 Joseph A. Smith, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 4, 1947 19 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28, 1946 to Feb 4, 1947 and that I last saw him alive on 2/4/47.

Immediate cause of death

Chronic Nephritis

Due to Chronic Nephritis

Due to Arteriosclerosis

Other conditions Old age

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Williams, M.D.

M. D. or other

Address Cumberland Date signed 2/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 11 1947
BUREAU V.A.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

01260

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
 City or town McCoole
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town McCoole
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.O. Address, Keyser, W. Va.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mary Anna Pugh

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Wade Hampton Pugh
Died 1933 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 24, 1889
 8. AGE: Years 57 Months 3 Days 14 If less than one day _____ hrs. _____ min.
 9. Birthplace Jennersville, Chester Co., Pa.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

FATHER 12. Name Frank Pierce Hood
 13. Birthplace Indiana
 MOTHER 14. Maiden name Margaret Simmers
 15. Birthplace York Co., Pa.

16. Informant Stella P. Fazenbaker
 Address Rantoul, Ill.

17. Burial Date thereof 2-11-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Queenspoint
 Location Keyser, W. Va.

18. Funeral director N. L. Rogers Funeral Directors
 Address Keyser, W. Va.

19. 24 11 47
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th. 19 47 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 19 47 to Feb. 8 19 47
 and that I last saw her alive on Feb. 8 19 47

Immediate cause of death Hemiplegia left DURATION 5 days
Asbestosis 8 years
Hypertension 20 to 30 years
Nephritis chronic
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. C. Griffin MD. M. D. or other _____
 Address Keyser, W. Va. Date signed Feb 9 47

RECEIVED
FEB 12 1947
BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M42)

01231

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital Yard

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 824 Buckingham Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dr. Knight Reynolds

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Evelyn Bang Reynolds6. (c) If alive, give age 43 years

7. Birth date of

deceased (mo., day, yr.)

June 24, 1899

8. AGE:

Years

Months

Days

If less than one day

47711

..... hrs. min.

9. Birthplace Keyser, Mineral County, West Virginia
(Town, county, and state)10. Usual occupation Physician11. Industry or business Private Practice

FATHER

12. Name

Francis C. Reynolds

13. Birthplace

West Virginia

MOTHER

14. Maiden name

Jessie Knight

15. Birthplace

West Virginia

16. Informant

Mrs. Knight Reynolds

Address

Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 8, 1947

(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director

John C. Wolford

Address

Cumberland, Md.19. Feb. 7, 1947
(Date rec'd by registrar)J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

about

20. DATE OF DEATH Feb. 5 1947 at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....
and that I last saw him Dead Feb. 5 1947

Immediate cause of death

Intercranial hemorrhage

DURATION

at
onceDue to a fracture of the skull
from a 22 caliber rifle bulletDue to despondencyseveral
years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 2.5.47Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) In his automobile
rear of Memorial Hospital
Means of injury Shot himself Injured at work?23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland, Md. Date signed 2-7-1947

RECEIVED
JAN 11 1947
BUREAU V.E.
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01262

90

1. PLACE OF DEATH:

County Allegany

City or town Morantown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Morantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. No 2 Frostburg, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Arthur Rizer

3. (b) Social Security Number

217-05-6552

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Pearl Mason Rizer

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) August 28th., 1893

8. AGE: Years 53 Months 5 Days 13 If less than one day hrs. min.

9. Birthplace Frostburg, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business W. Md. R. R. Co.

12. Name William Rizer

13. Birthplace Frostburg, Md.

14. Maiden name Sarah Williams

15. Birthplace Mt. Savage, Md.

16. Informant Mrs. Arthur Rizer Md.

Address Morantown, R. D. No 2 Frostburg

17. Burial 2-14-1947
(Burial, cremation, or removal) Date thereof (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 2-12 47 Mrs. Nancy A. Rizer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Dead Feb 11 1947

Immediate cause of death

Cardiac dilatation

DURATION

at

once

Due to Bronchial Asthma

About two years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 2-17-1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
FEB 15 1947
BUREAU V.A.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14-2

CERTIFICATE OF DEATH

01263
Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 218 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Girl Schardt

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7, 19478. AGE: Years Months Days It less than one day
1 hrs. 30 min.9. Birthplace Cumberland Allegheny Co, Ind
(Town, county, and state)10. Usual occupation Child

11. Industry or business

12. Name Harold Schardt13. Birthplace Cumberland Ind.14. Maiden name Mary Knapp15. Birthplace Cumberland Ind16. Informant Harold SchardtAddress 218 Columbia St Cumberland17. Burial Date thereof Feb 8, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. CemeteryLocation near Cumberland, Ind.18. Funeral director John J. HaferAddress Cumberland Ind.19. Feb 8 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1947 at 2:17 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7, 1947 to Feb. 7, 1947 and that I last saw him alive on Feb. 7, 1947

Immediate cause of death

DURATION

Hydrops fetalis
Due toErythroblastosis
Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Clay E. LuerAddress Cumberland M. D. or other23. SIGNATURE Clay E. LuerDate signed 7/7/47

Ans - 77

7-2-20

Fyp 1, 5 lat

...but I am not sure...

1-35

John G. Thompson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-6)

CERTIFICATE OF DEATH

01264

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 66 years 7 mos 29 days
 Hospital, institution, or street address where death occurred: Jackson Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 Jackson Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Janet Ross Leggie

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Isaac Leggie
 6. (c) If alive, give age 4 years
 7. Birth date of deceased (mo., day, yr.) June 10, 1880
 8. AGE: Years 66 Months 8 Days 30
 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1947, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Feb. 5 1947 and that I last saw him alive on Feb. 4 1947.

Immediate cause of death

Toxin Thyroid

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Henry M. Hodges M. D. or otherAddress Lonaconing, Md. Date signed Feb. 5 1947

9. Birthplace Lonaconing, Allegany Co., Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name Charles Ross
 13. Birthplace Scotland
 14. Maiden name Janet Stevenson
 15. Birthplace Scotland
 16. Informant Mrs. Cora Dine
 Address Lonaconing, Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 7, 1947
 (month) (day) (year)
 Cemetery or crematory Oak Hill Cemetery
 Location Lonaconing, Md.
 18. Funeral director G. E. Eighon
 Address Lonaconing, Md.
 19. Feb 7 1947 Janette M. Neal Registrar
 (Date rec'd by registrar)

RECORDED
FEB 11 1947
BUREAU V 8

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01265

CERTIFICATE OF DEATH

Reg. Dist. No. 40

DR. W.F. WILLIAMS

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town LONACONNING
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

MR. FRED R. SLOAN
4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

3. (b) Social Security Number

None

6. (b) Name of husband or wife MARGARET BELL

6. (c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) AUGUST 3, 1883

8. AGE: Years 63 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation RETIRED MERCHANT

11. Industry or business

12. Name JAMES M. SLOAN

13. Birthplace MARYLAND

14. Maiden name ELIA FREDERICK

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal Which?) Date thereof Feb. 19, 1947 (month) (day) (year)

Cemetery or crematory Oak Hill Cem

Location Lonacoring, Md

18. Funeral director M. Eichhorn

Address Lonacoring, Md.

19. Feb. 19, 1947 J. P. Franklin, MD (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 16, 1947, at 11:50 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 2, 1947, to Feb. 16, 1947, and that I last saw him alive on Feb. 1, 1947.

Immediate cause of death Cardiovascular

Due to Renal disease

Due to (Anemia)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams

Address Cumberland Date signed 2/17/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1947

BUREAU V 8

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 01366
4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? Expired when admitted.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town R.F.D. 3 Mt. Pleasant Road
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Cumberland, Rural
(If rural, give LOCATION)2. (a) If veteran, name war World War I.

3. (a) FULL NAME

Charles Spencer Slonaker

3. (b) Social Security Number

216-18-1673

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

maleWhiteMarried6. (b) Name of husband or wife Ruth Conway Slonaker6. (c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) August 30, 18928. AGE: Years Months Days If less than one day
54 5 22 hrs. min.9. Birthplace White Hall, Virginia
(Town, county, and state)10. Usual occupation Brakeman11. Industry or business B & O TPR12. Name James T. Slonaker13. Birthplace Gorantown, W. Va.14. Maiden name Lora Belle De Haven15. Birthplace De Haven, Virginia16. Informant Mrs. Samuel ClarkAddress Rt. 2, Cumberland, Md.17. Burial Date thereof February 25, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union Grace CemeteryLocation Mason Road, Cumberland, Md.18. Funeral director John J. WagnerAddress Cumberland, Md.19. Feb. 25, 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 19 47 at 9.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him alive Dead Feb. 22 19 47

Immediate cause of death

Pulmonary hemorrhage

DURATION

1-3/4 hrsDue to Shot self with a 12 gauge
shotgun, left side of chestDue to despondency

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Feb 22/47Where did injury occur? home Allegany Md.
near Cumberland (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury as above

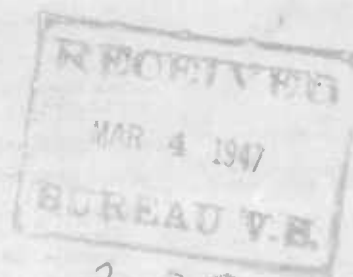
Injured at work?

Deputy Medical Examiner Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 2-23/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 135-6

01267

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County SOMERSETCity or town MEYERSDALE
(If outside city or town limits, write RURAL and give nearest town)Street No. BOX 216
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ETHEL SMITH

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, or divorced

FEMALEWHITEMARRIED6. (b) Name of husband or wife JESSE SMITH6. (c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) March 14, 19248. AGE: Years 28 Months 11 Days 8 If less than one day
hrs. min.9. Birthplace PENNA.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name WILLIAM CHRISSEY13. Birthplace PENNA14. Maiden name EDITH SMITH15. Birthplace PENNA.16. Informant Jesse L. SmithAddress Meyersdale, Pa17. Burial Date thereof Feb 25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meyersdale PaLocation Trice Cemetery18. Funeral director J. P. Franklin, M.D.Address Meyersdale Pa19. Feb. 22, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

NOON

20. DATE OF DEATH FEB. 22, 1947 at 12:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-14-47 to 2-22-47and that I last saw her alive on 2-22-47

Immediate cause of death

Ether anesthesia following operation to relieve nephropathy

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Abnormal mobility of kidney. Date of op. 2-22-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

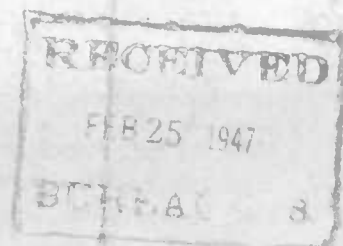
Manner of injury Injured at work?

23. SIGNATURE Howard P. Tolson, M.D. M. D. or otherAddress Cumberland Md Date signed 2-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Allegany
 City or town Frostburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 Taylor St
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Albert Garfield Stromson

3. (b) Social Security Number

214-07-5752

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Sarah Stevenson

6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Apr. 16 - 1880

8. AGE: Years 66 Months 9 Days 16 hrs. 16 min.

9. Birthplace Midland Alleg Co, Md
 (town, county, and state)

10. Usual occupation Retired

11. Industry or business Genl

12. Name Jacob Stromson

13. Birthplace Cumberland Md

14. Maiden name Mary Marty

15. Birthplace Germany

16. Informant Albert Stromson

Address 1 Taylor St. Frostburg Md

17. Burial, cremation, or removal, Which? Burial Date thereof 2-5-47
 (month) (day) (year)

Cemetery or crematory Allegany Co

Location Frostburg Md

18. Funeral director Jas H. Grafer

Address Frostburg, Md

19. 2-4 (Date rec'd by registrar) 19 47 for P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 47 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him Dead Feb 3 19 47

Immediate cause of death Shock following laceration to abdomen of the abdomen and incision

Due to sub-peritoneal hemorrhage from fractured pelvis

Due to knocked by automobile truck on Route 40 one mile West of Frostburg Md 1-19-47

Other conditions 4-5-6-7-8 ribs left side of chest fractured

(Include pregnancy within 3 months of death)

Major findings of operations paralytic ileus & sub-peritoneal hemorrhage

Date of op. 2-2-47

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-29-47

Where did injury occur? on highway Allegany Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 40

Means of injury knocked by automobile truck Injured at work? no

Deputy Medical Examiner Allegany Co

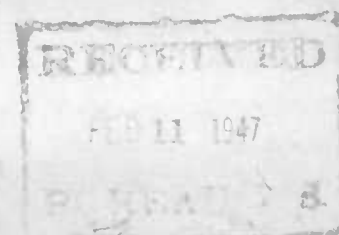
23. SIGNATURE H. V. Denning Md M. D. or other

Address Cumberland Md Date signed 2-3-1947

MARGIN RESERVED FOR BINDING

VS A15 9 45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01269

40

Reg. Dist. No.

DR HODGES

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 MINUTES

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 9 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. RT #5 CRESAP PARK, BOX 148

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

BABY BOY STEWART

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALEWHITESINGLE

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

FEB 20, 1947

8. AGE:

Years

Months

Days

If less than one day

..... hrs. 9 min.9. Birthplace CUMBERLAND, ALLEGANY CO., MD.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name STEWART GARLAND Stewart13. Birthplace MARYLAND, Cumberland

MOTHER

14. Maiden name VAUDA McDONALD15. Birthplace W. VA. Seasideville, W. Va.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. CREMATION

(Burial, cremation, or removal. Which?)

Date thereof FEB. 22 47

(month) (day) (year)

Cemetery or crematory MEMORIAL HOSPITALLocation CUMBERLAND, MD.18. Funeral director Same as above

Address.....

19. Feb. 22

(Date rec'd by registrar)

19. 47

J. P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 20 19. 47 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 20 19. 47 to Feb 20 19. 47and that I last saw him alive on Feb 20 19. 47Immediate cause of death Difficult laborLarge baby

DURATION

20 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury W.D. Hodges, M.D.

Injured at work?

23. SIGNATURE.....

Cumberland, Md. M. D. or other

Address.....

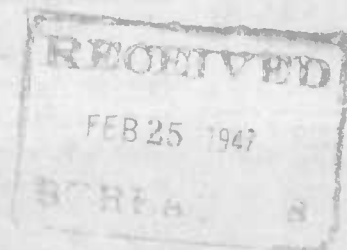
Date signed 2/20/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

01270

40

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 32 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALL GANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 211 CENTRAL AVE.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. ANNA TRIEBER Sarah Ann Treiber

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED6.(b) Name of husband or wife JOHN J. TRIEBER6.(c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) 5/13/77

8. AGE:	Years	Months	Days	If less than one day
<u>69</u>	<u>9</u>	<u>15</u>	<u>hrs.</u>	<u>min.</u>

9. Birthplace MARYLAND Lancaster
(Town, county, and state)10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name RUSHTON, GEORGE13. Birthplace ENGLAND14. Maiden name EVANS, MARION15. Birthplace WALES16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Burial Date thereof March 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation Cumberland, Md.18. Funeral director John J. PorterAddress Cumberland, Md.19. March 1, 1947 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 28 1947, at 9:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1947, to Feb. 28 1947and that I last saw him/her on February 28, 1947Immediate cause of death Myocardial infarctionDue to arteriosclerosisDue to hypertension of long standingOther conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operation Pyloric obstruction

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Haverkins M. D. or otherAddress Cumberland, Md. Date signed 3-1-47



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred Miners Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Julia Villa

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife John Villa

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) February 18, 1885

8. AGE: Years 61 Months 11 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Austria Hungary
(Town, county, and State)

10. Usual occupation housewife

11. Industry or business home

12. Name Barnet Kmetz

13. Birthplace Austria

14. Maiden name Eva Kerchik

15. Birthplace Austria

16. Informant John Villa

Address Eckhart Md.

17. Burial Date thereof Feb 12 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg Md.

18. Funeral director J. J. Ours

Address Frostburg Md.

19. 2-11 1947 Wm. Nancy & Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947, at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1947 to Feb 9 1947 and that I last saw her alive on Feb 9 1947

Immediate cause of death _____ DURATION _____

Broncho Pneumonia 2 Day

Due to _____

Influenza 3 Day

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

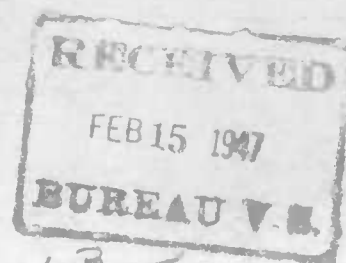
23. SIGNATURE Wm Lane Jr MD

Address Frostburg Md Date signed 2-11-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
Cumberland
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County Pennelton
 City or town Riverton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Blanche Warner

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) August 14 1884
 6. (c) If alive, give age _____ years

8. AGE: Years 62 Months 5 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Riverton, Pennelton Co., West Va.
 (Town, county, and state)

10. Usual occupation House11. Industry or business "12. Name W. P. Warner13. Birthplace Riverton, W. Va.14. Maiden name Anise Thompson15. Birthplace Riverton, W. Va.16. Informant Fred WarnerAddress Rt 5, Cumberland, Md.

17. Burial Date thereof 2/9/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lambert CemeteryLocation Riverton, W. Va.18. Funeral director F. R. BrownAddress Franklin, W. Va.

19. Feb 8 1947 Joseph D. Zimble, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947 at 2-50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1947 to February 6 1947
 and that I last saw him alive on February 6 1947

Immediate cause of death apoplectic stroke
 DURATION 5 days

Due to arterial hypertension 10 years

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

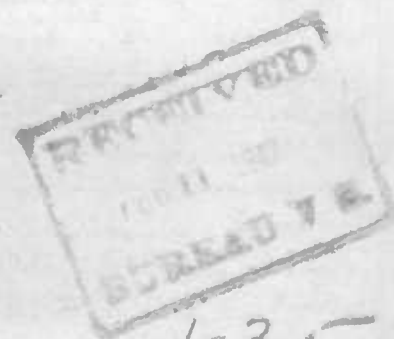
23. SIGNATURE L. Brings M.D. M. D. or other

Address 58 Greene St. # Date signed 2-7-47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 yrsHospital, institution, or street address where death occurred Memorial HospitalHow long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 511 Louisiana Ave
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

James Russell Williams

3. (b) Social Security Number

105-07-95234. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary Meagher6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) March 4, 18978. AGE: Years 49 Months 11 Days 20 If less than one day hrs. min.9. Birthplace Cumberland, Allegany Co Md
(Town, county, and state)10. Usual occupation Brotherman11. Industry or business B. & O. Railroad12. Name John W. Williams13. Birthplace Cumberland Md.14. Maiden name Lucinda Lynn15. Birthplace Cumberland Md.16. Informant Mrs. J. R. WilliamsAddress 511 Louisiana Ave - Cumberland17. Burial Date thereof Feb 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation Cumberland, Md.18. Funeral director John J. HaferAddress Cumberland, Md.19. Feb 27 19 47 J. P. Rankin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 19 47 at 8:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 19 44 to Feb 24 19 47and that I last saw him alive on Feb 24 19 47Immediate cause of death Acute myocardial infarctionDue to Coronary ArteriosclerosisDue to Myocardial InfarctionOther conditions Myocardial Infarction

(Include pregnancy within 8 months of death)

Major findings of operations NoneAutopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of Feb 24

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel JacobsonAddress 153 Liberty St Date signed 2/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten notes at top left, including "I will have" and "112".

Handwritten notes at top right, including "112" and "I will have".

Handwritten text in the middle section, possibly "I will have".

Handwritten text in the middle right section, including "I will have" and "112".

Handwritten text in the lower middle section, including "I will have" and "112".

RECEIVED
MAR 4 1942
BUREAU V.A.

2-35

Handwritten notes at the bottom, including "I will have" and "112".

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11274

40

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

Route 3 Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny

City or town Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 3 Cumberland
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Harry Doyle Zembower

3. (b) Social Security Number

217-10-6729

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Alice Wentling

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1889

8. AGE: Years 58 Months 0 Days 25 If less than one day hrs. min.

9. Birthplace Bedford Valley, Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation Pit Worker

11. Industry or business Kelly Springfield Tire Co.

12. Name Charles Zembower

13. Birthplace Pa.

14. Maiden name Virgie Dressler

15. Birthplace Pa.

16. Informant Mrs. H. D. Zembower

Address Route 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 18, 1947
(month) (day) (year)

Cemetery or crematory G.O.S. Co. Cemetery

Location Centerville, Pa.

18. Funeral director John J. Haler

Address Cumberland, Md.

19. Feb 18, 1947 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 47 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Feb 9, 1947

and that I last saw him alive on Feb 15 19 47

Immediate cause of death

Angina Pectoris

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE T. Barclay Hunter M.D. or other

Address Cumberland, Md. Date signed 2/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947

[Faint handwritten notes, possibly "The..."]

[Faint handwritten notes, possibly "The..."]

[Faint handwritten notes, possibly "The..."]

RECEIVED
FEB 25 1947
BORNEO

2-35

[Faint handwritten notes, possibly "The..."]